The Rhode Island Health Care for Families Act 2004
Report to the General Assembly

Submitted by:

Jane A. Hayward
Managing Director
Rhode Island Office of Health and Human Services

Ronald A. Lebel, Esq.
Acting Director
Rhode Island Department of Human Services

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EXECUTIVE SUMMARY

The Rhode Island Health Care for Families Act of 2004 directed the Department of Human Services, in collaboration with the Department of Health, to do the following:

> ". . . Develop a plan for a primary care pilot program for uninsured residents in the state. This program may include enrollee premiums and co-insurance payments that are income-based with premiums and co-insurance subsidized by the state. The pilot program may also include catastrophic or reinsurance coverage provided under the auspices of the state. In designing the program, the director may consider a variety of service delivery and financing models including capitation payments to private physicians, a buy-in program under RIte Care and coverage arrangements purchased from qualified community health centers."

Key finding: Employer sponsored health care coverage is deteriorating in Rhode Island
To develop this plan a workgroup comprised of the two department's staff and consultants reviewed information on health care coverage, the uninsured, health care costs and solutions tried by other states. Key findings included:

- The majority of Rhode Islanders receive health care coverage through their employment.
- The majority of the uninsured are employed but are not covered by their employer.
- The uninsured are not a static population, but move in and out of coverage status throughout the year.
- Employer-sponsored coverage has been eroding since 2000.
- The major reason for this erosion is the increasing cost of health care coverage (i.e., the cost of health care coverage has far surpassed the increase in inflation and wages in the past five years).
- Acute care hospitals provide more than $60 million of care each year to the uninsured.
- Many solutions have been or are being tried in other states. The most successful have some degree of subsidy by the state.
- Nationally, minimum benefit plans have been tried often but do not prove successful or popular with employer or employees.
- Most efforts to date in other states shift costs to taxpayers, employees or providers (reduced or no fees), rather than attempting to reduce the underlying cost of health care.
- Access to primary care alone without access to diagnostic services, pharmaceuticals and specialty care and other needed treatment is not medically sound and could result in "increased pressure on safety- net providers and growing waits for follow-up appointments," a situation already reported by RI Hospital and others.[1]

[1] Felland, Felt-Lisk & McHugh, *Health Care Access for Low-Income People: Significant Safety-Net Gaps Remain,* Center for Studying Health System Change, Issue Brief 84, June 2004

Proposal to Develop a Health Plan for Rhode Island

Given the foregoing as a backdrop, the following is a proposal to develop a health plan that is responsive to the needs of all stakeholders: employers, employees, insurers and agents and providers.

Objectives: Address the affordability of health care and reduce the uninsured

- The populations "at risk of uninsurance" need more choices for coverage. At risk populations include:
    - Working individuals and their dependents whose employers do not offer health care coverage , who are not eligible for their employers' coverage or cannot afford or are struggling to afford coverage;
    - Self-employed individuals and dependents who cannot afford or are struggling to afford coverage;
    - Unemployed individuals and their dependents who are uninsured and cannot afford or are struggling to afford COBRA or "direct pay" coverage.
- Health insurance rates, particularly for small employers, should have reasonable and stable annual trends, as well as minimal year-to-year volatility, resulting in an increased number of employers who offer health insurance to their employees.
- When offered, enrollment in employer-sponsored health insurance should be affordable to all workers, resulting in:
    - An increased number of working Rhode Islanders enrolling in employer-sponsored coverage
    - An increased number of working families switching from RIte Care to RIte Share

Approach

- The State should design and assess the feasibility of a plan, with public input, which should be offered to Rhode Island small businesses.
- The health plan should incorporate the flexibility to include features that ensure affordability for employers and employees.
- The State should issue a Request for Proposals for health insurers to offer this plan.
- The State should create a reinsurance program for hospital costs, built around the principle of supplementing the cost of hospital services for all enrollees in the plan.
- The State should build on the lessons-learned from the RIte Care program, in particular, the oversight and monitoring function, which should ensure the appropriate implementation, operation, reporting, and evaluation of the plan in accordance with terms set by the State.

Design Principles

The design principles for the plan are as follows:

- Utilize value-based purchasing and "pay for performance" methods to ensure quality, utilizing access and quality standards as well as incentives for quality improvement.
- Provide incentives to providers and enrollees to emphasize access to primary and preventive care, as well as management of chronic diseases.
- Make the quality and cost of services transparent.
- Create a benefit design that encourages rational consumer behavior based on quality and cost considerations.
- Incorporate consumer education as well as consumer incentives to promote healthy behaviors.
- Incorporate employer support and incentives to promote workplace wellness activities.
- Provide affordable access to quality, medically necessary care.
- Provide access to a coordinated, accessible organized delivery system that incentivizes enrollees to seek and receive care in the most appropriate and lowest cost setting, incorporating a quality, accessible system of community-based health services and as little as possible reliance on institutional-based services.
- Build on evidence-based practice standards for covered services and service delivery models.
- Make the plan simple to navigate for enrollees and providers.
- Be flexible in design to be able to incorporate new design concepts, such as Health Savings Accounts.

Financing Principles

The financing principles for the plan should be as follows:

- Medically necessary services in the lowest-cost setting should be fully insured.
    - Services components covered by the premium (i.e., financed by the monthly combined employer/employee premium) should include:
        - The full cost of primary/preventive care, disease management, care management, non-emergency sick care in community-based settings, and patient education
        - The full cost of medically necessary specialty and ancillary service (e.g., specialists, imaging, and laboratory) delivered by providers that are both quality-qualified and that are the least costly to the insurer.
        - The full cost of medically necessary hospital care at qualified facilities/institutions offering a payment mechanism that emphasizes cost-efficient care.
- Qualified providers who participate in the plan at a higher contractual rate should also be accessible; however, the additional cost beyond the least cost "allowance" should be borne by the enrollees and should not be part of the "insured" premium (whose costs are passed on to the employer and all employees).
- Employer-paid and employee-paid monthly premiums should assure access to affordable medically necessary care for all members. Members choosing to use higher cost care settings pay the additional cost above the allowable amount.

Next Steps
This proposal will be referred to the Health Care Cabinet, newly constituted by the Governor, which will be chaired by the Commissioner of Health Insurance. The Cabinet will continue to develop and, if recommended, implement the proposal. Activities to be considered by the Cabinet shall include:

- Meeting with stakeholders to elicit their input on the proposed objectives, approach, design principles, and financing principles
- Refining or adjusting the proposed objectives, approach, design principles, and financing principles as needed
- Identifying opportunities or limitations in State law to the plan, and ways to capitalize on the opportunities or overcome the barriers
- Fleshing out the details of the plan
- Conducting a financial feasibility study of the proposed plan

INTRODUCTION

The Rhode Island General Assembly, in conjunction with the Sundlun, Almond, and Carcieri Administrations, has long had an interest in the population of the State of Rhode Island without health insurance coverage. The State of Rhode Island has approached uninsurance in the population incrementally. In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1)[2] by the U.S. Department of Health and Human Services (HHS) to develop and implement a mandatory Medicaid managed care demonstration program called RIte Care. RIte Care, implemented in August 1994, has the following general goals:

- To increase access to and improve the quality of care for Medicaid families
- To expand access to health coverage to all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

The pursuit of this waiver flowed from enactment in 1993 of Section 42-12.3 of the General Laws (G.L.) of Rhode Island. The intent of the Rhode Island General Assembly was explicit, as shown in Section 42-12.3-2:

> "It is the intent of the general assembly to assure access to the comprehensive health care by providing health insurance to all Rhode Islanders who are uninsured."

Thus, for more than a decade Rhode Island has pursued this intent.

More recently, the Rhode Island General Assembly has directed the Rhode Island Department of Human Services (DHS) to examine options to address the ongoing uninsurance problem in the State. R.I.G.L. 40-8.4, which incorporated Health Reform Rhode Island 2000 initiatives, directed DHS, in Section 40-8.4-7, to:

> ". . . investigate and develop opportunities for individuals and/or employers to buy into, at the individual's and or employer's expense, one or more programs the department may establish under this chapter or chapter 12.3 of title 42 to address uninsurance among Rhode Islanders . . ."

In addition, the recently enacted Health Care for Families Act of 2004 added section 40-8.4-16 to the General Laws of Rhode Island and requires DHS to:

> ". . . Develop a plan for a primary care pilot program for uninsured residents in the state. This program may include enrollee premiums and co-insurance payments that are income-based with premiums and co-insurance subsidized by the state. The pilot program may also include catastrophic or reinsurance coverage provided under the auspices of the state. In designing the program, the director may consider a variety of service delivery and financing models including capitation payments to private physicians, a buy-in

[2] The waiver currently runs through July 31, 2005.

program under RIte Care and coverage arrangements purchased from qualified community health centers."

This report to the General Assembly builds on what DHS, in consultation with the Rhode Island Department of Health, has learned from RIte Care and RIte Share, the State's premium assistance program for lower-income individuals with access to employer-sponsored insurance, and from consideration of activities in other parts of the country to address the problem of access to affordable health care and uninsurance. The report is structured as follows:

- Health Care Coverage in Rhode Island
- The Uninsured in Rhode Island
- Health Care Costs
- Solutions Tried in Other States
- Rhode Island Proposal

HEALTH CARE COVERAGE IN RHODE ISLAND

Population distribution by Insurance Status

Estimates based on the US Census Bureau's Current Population Survey indicate that the 2002-2003 distribution of the Rhode Island population by insurance status was as follows:

- Employer sponsored coverage 57%
- Individual coverage 4%
- Medicare 13%
- Medicaid 16%
- Uninsured 10%[3]

Rhode Island's rate of coverage by employers, Medicaid and Medicare was slightly higher than the rate nationally, and it was lower than the national rate for individual coverage and the uninsured.

Coverage Trends

In 1995, eighty-seven (87) percent of Rhode Island's population had either public or private health care coverage. Over the ensuing five years, with the implementation and expansion of RIte Care and an increase in employer sponsored coverage, the population with health care coverage rose to a high of 94 percent. Between 2000 and 2003, the percent of the state's population with health care coverage declined to 90 percent as a result of almost a ten percentage point reduction in the population covered through employment. [4]

Health Insurers

Rhode Island has three dominate health insurers that offer coverage in four market segments:

Table 1
Health Insurers Offering Coverage by Market Segment[5]

Health Insurer	Market Segment			
	Commercial	**Medicare**	**Medicaid**	**Medicare Supplement**
Blues Cross & Blue Shield of RI[6]	yes	yes	yes	yes
United Healthcare of New England	yes	yes	yes	no
Neighborhood Health Plan of RI	no	no	yes	no

[3] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys. Total US numbers are based on March 2004 estimates.
[4] Griffin, J, *Profiles and Trends of the Uninsured in Rhode Island*, RI Medicaid Research and Evaluation Project, May 2004.
[5] Annual Report 2002, Governor's Advisory Council on Health
[6] Includes BlueCHiP

There were 779,223 covered lives enrolled in Rhode Island private health insurance companies as of December 31, 2001. By far, Blue Cross and Blue Shield of RI (including BlueChip) had the largest market share at 69%, followed by United Health Care of New England at 22% and Neighborhood Health Plan of RI at 10%.

Table 2
2001 Total Enrollment by Health Insurer[7]

Health Insurer	Total Enrollment 2001	Percent
Blues Cross & Blue Shield of RI[8]	536,303	69%
United Healthcare of New England	116,829	22%
Neighborhood Health Plan of RI	74,603	10%
TOTAL	779,223	100%

Employer Sponsored Coverage

As noted above, employers in Rhode Island are the largest purchasers of health care coverage, however, employer sponsored coverage has been eroding since 2000. That is, in 2000, the proportion of Rhode Islanders with employer-sponsored coverage was 77.7 percent, whereas in 2003 it declined significantly to 68.4%[9] .

In 1999, the Rhode Island Department of Health undertook a survey[10] of employers regarding health insurance coverage. For employed adults, the employer's size bears on whether employees are offered health benefits. Table 3 shows that the larger the employer, the more likely health benefits are offered to some or all employees. Overall, 21 percent of all Rhode Island employers did not offer health insurance coverage in 1999. Employers with 3 to 9 workers were least likely to offer coverage (68 percent offered) followed by those with 10 to 24 employees (89 percent offered). Forty-two percent of uninsured workers were in the service industries and 34 percent were in retail trades.

Cost was cited by employers as the primary reason for not offering coverage.

[7] Annual Report 2002, Governor's Advisory Council on Health
[8] Includes BlueCHiP
[9] U. S. Census Bureau. *Op. Cit.*
[10] Buechner, J. S. "Health Benefits Offered by Rhode Island Employers, 1999", *Health By the Numbers*, 2(10), October 2000.

Table 3

Percentage of Employers Who Offer Health Benefits

to Some or All Employees by Employer Size

Employer Size	Rhode Island	United States
3 – 9 employees	68%	55%
10 – 24 employees	89%	72%
25 – 49 employees	93%	86%
50 – 199 employees	97%	92%
200+ employees	100%	99%

Making health benefits available does not, however, mean that they are available to everyone. In Rhode Island in firms where health coverage was offered, 77 percent of employees were eligible to enroll and 23 percent were not. Restrictions on eligibility often had to do with full- versus part-time employment (or number of hours worked), as Table 4 shows. Full-time employees were more likely to be offered coverage than part-time employees, irrespective of employer type or the number of employees.

Table 4

Eligibility for Health Coverage among Rhode Island Employers Who Offer

Type of Organization/Number of Employees	Percent of Full-Time Employees Eligible for Coverage	Percent of Part-Time Employees Eligible for Coverage
Private		
3 – 9 employees	89.5%	28.4%
10 – 49 employees	90.5%	27.8%
25 – 49 employees	88.3%	19.4%
50 – 99 employees	90.1%	25.5%
100+ employees	93.0%	38.8%
Government (3+ employees)	96.7%	30.5%
All employers	**91.6%**	**32.5%**

Seventy-four percent of employers who offered health coverage also restricted eligibility through waiting periods for new employees and for previously unenrolled employees, and for 60 percent of these employers the waiting period was 30 days or more.

The offer of coverage does not necessarily translate to enrollment. Overall, only 75 percent of eligible employees elected to do so, with greater enrollment among full- rather than part-time employees (80 percent versus 36 percent) and among government rather than private employees (94 percent versus 75 percent). Most employers offered their employees with families the option of family coverage in addition to coverage for the employee, and 54 percent of full-time employees who were enrolled had family coverage as did 49 percent of part-time employees.

The 1999 Employer Survey will be repeated this year by the Department of Health and the Department of Human Services under a grant from the Robert Wood Johnson Foundation's State Coverage Initiative Program.

Individual Market

Blue Cross and Blue Shield of Rhode Island (BCBSRI) is the only carrier offering coverage directly to individuals in Rhode Island. BCBSRI is required under R.I. Gen. Laws Section 27-19.2-10(a) (2) to provide this coverage as part of its corporate obligation.

The individual market serves those who do not have access to employer –sponsored coverage. Direct pay (the term used by BCBSRI for products sold in the individual market) accounts for approximately 2.3% of BCBSRI business. According to the carrier, approximately 13,500 individuals are covered under direct pay. Direct pay is divided into Pool I and Pool II. Subscribers who pass a health screen are enrolled in Pool II. Those who do not pass are enrolled into Pool I. There are four products to choose from (i.e., Standard, Economy, Healthmate Coast-to-Coast, and BlueChip). The most comprehensive plan is the Standard plan. Annual premiums for the Standard plan for Pool I subscribers are $5,657 for an individual and $10,653 for a family. The premiums for subscribers who pass the health screen and are placed in Pool II are lower than for those in Pool I; 55% of direct pay subscribers are in Pool I.

In September 2004, BCBSRI filed for rate increases for these products ranging from 16.3% to 17.9%. After three contentious public hearings on the matter, on November 23, 2004, the RI Department of Business Regulation disapproved the requested increase, based largely on the lack of affordability.[11]

Medicare

Medicare is a Federal health care program that covers an individual and his/her spouse who worked for at least 10 years in Medicare-covered employment, is at least 65 years old and a citizen or permanent resident of the United States. Individuals also qualify for Medicare coverage if they are under age 65 and have a disability or have end-stage renal disease (permanent kidney failure requiring dialysis or transplant). In 2003, 172,474 Rhode Islanders were covered by Medicare.[12] Medicare recipients may purchase Medicare supplemental insurance from Blue Cross & Blue Shield of RI, which pays for a portion of Medicare co-

[11] RI Department of Business Regulation DBR No. 04-1-0144 Decision related to BCBSRI Petition to Increase Rates for Class DIR, November 23, 2004.

[12] Kaiser State Health Facts, www.statehealthfacts.kff.org

payments and deductibles, or they may enroll in a Medicare managed care plan. In 2001, 33 percent of Rhode Island's Medicare population was enrolled in a managed care plan. This percentage was the highest in New England and nearly two and one-half times the national rate.[13]

Medicaid

Medicaid is a joint Federal and State sponsored health care program that covers individuals and families with limited incomes and resources. In 2003, 176,824 Rhode Islanders were enrolled in Medicaid. The population was distributed among four sub-populations as follows[14]:

- Adults with Disabilities 24,543
- Elderly 19,237
- Children & Families in Managed Care 120,895
- Children with Special Health Care Needs 12,149

Adults with disabilities and the elderly are covered by "fee-for-service" Medicaid (i.e., Medicaid contracts directly with and makes payments to providers to provide health care for these populations). Children and families in managed care and children with special health care needs[15] are enrolled in Rhode Island's Medicaid managed care program, RIte Care. In June 2003, RIte Care eligible individuals and families were enrolled in one of three health plans as follows:

- Neighborhood Health Plan of RI 67,558
- United Health Care of New England 41,062
- BlueChip 10,637[16]

Legislation enacted in 2000 created the RIte Share program, a Medicaid premium assistance program which pays all or part of an eligible families employer-based health insurance cost, as long as the cost is less than a family's cost of coverage under RIte Care. As of June 2003, 4,268 individuals were enrolled in employer-sponsored health coverage through the RIte Share program. Coverage for each enrollee in RIte Share costs half as much as the coverage for a RIte Care enrollee. The majority of RIte Share recipients are enrolled in a Blue Cross and Blue Shield of RI health care coverage product.

Public funding of Uncompensated Care

Nationally, it is estimated[17] that hospitals accounted for more than 60 percent of uncompensated care while office-based physicians and clinics and other direct care programs each accounted for just under 20 percent of uncompensated care. In Rhode Island, the only publicly available information the funding of care for the uninsured is pertains to health centers and hospitals. The following can be documented for Rhode Island:

[13] Annual Report 2002, Governor's Advisory Council on Health.
[14] Medicaid Annual Report 2003
[15] Some children with special health care needs remain in fee-for -service Medicaid at this time
[16] Medicaid Annual Report 2003
[17] Hadley, J. and J. Holahan. *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* The Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.

- In 2004, community health centers received $5 million in federal funds which were used to offset the cost of providing care to the uninsured, and in addition, billed $4.62 million in charges to the uninsured[18]

- In 2003, uncompensated care in acute care hospitals totaled $60 million and was comprised of[19]:

    - Hospital charity care was $15.7 million, or 0.8 percent of hospital revenue. Charity care is defined as charges for services for which payment was waived

    - Hospital bad debt was $45.5 million, or 2.3 percent of hospital revenue. Bad debt is defined as charges that are billed for services rendered but are not collected.

[18] Rhode Island Community Health Center Fact Book, November 2004
[19] Cryan, Bruce, *Hospital Community Benefits Report 2003, RI Department of Health, August 2004.*

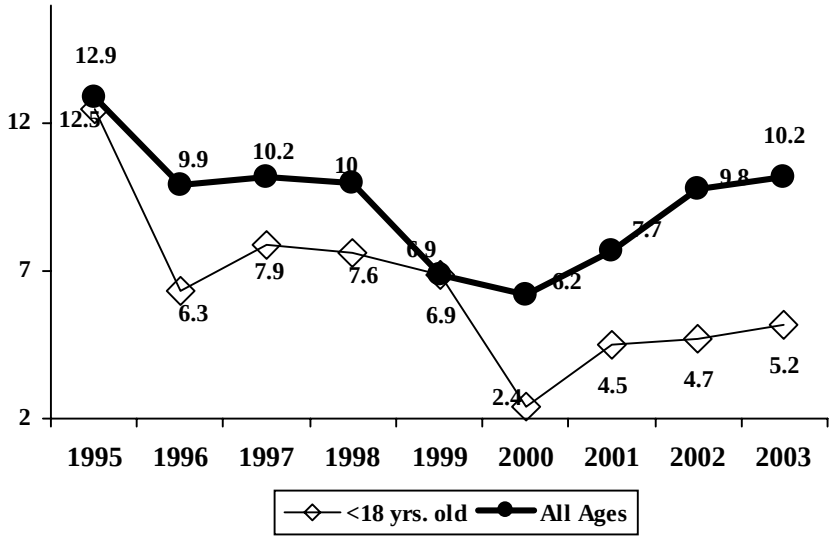
THE UNINSURED IN RHODE ISLAND

Profile of the Uninsured

Among the nation's lowest in the late 1990's and early 2000's, the rate of uninsured in Rhode Island has been rising since 2000 as Figure 5 shows. As already stated, this increase in the uninsured is a result of the erosion of employer-sponsored coverage. According to the most recent *Current Population Survey* (CPS)[20], the current rate of uninsurance in the state is 10.2 percent overall and 5.2 percent for children.

Figure 1

Percent of Uninsured Rhode Islanders by Age Group: 1995 - 2003



Source: Current Population Survey

The Health Interview Survey (HIS), conducted periodically by the Rhode Island Department of Health, is a valuable tool for understanding the characteristics of the uninsured population. The most recent analysis of HIS data summarizes 1990, 1996, and 2001 survey results[21]. In 2001, a random sample of 2,600 Rhode Island households were interviewed by telephone for the HIS, covering 6,877 individuals. Summary findings are as follows:

- **Most of the uninsured are employed** – Rhode Island's uninsured population was primarily employed (61.1 percent); 16.4 percent of the uninsured were temporarily unemployed but actively seeking work and 22.5 percent were not in the labor force.

[20] U.S. Census Bureau. *Current Population Survey, September 2004*.

[21] Bogen, K. *Who Are the Uninsured in Rhode Island? Demographic Trends, Access to Care, and Health Status for the Under 65 Population*. RI Medicaid Research and Evaluation Reports, September 2004.

- **The uninsured are of low and middle incomes**–One-quarter of all Rhode Islanders aged 18 to 64 who were under 100 percent of the FPL were uninsured. Another quarter (26%) were near poor, between 100% and 200% FPL and the remaining half were middle income (above 200% FPL).

- **The uninsured are young** – Eighteen to thirty-four-year-olds comprised 45 percent of the uninsured, and teens and children added another 14 percent. The remaining 41percent were 35 to 64 years of age.

- **More than half of the uninsured are male** – Fifty-eight percent of the uninsured were male.

- **More than half of the uninsured are single** – Fifty-six percent of the uninsured were not married. Only 26 percent of the uninsured were married and 18 percent were widowed, divorced, or separated.

- **The uninsured are less educated than the insured** – Nearly half (46 percent) of the uninsured between the ages of 17 and 64 had completed high school only; 23 percent had completed less than high school and 31 percent had received some education beyond high school.

- **The uninsured live in large households** – Although individuals living alone had the highest rate of uninsurance (14 percent), they comprised only about 11 percent of the uninsured. Sixty-six percent of the uninsured lived in three-, four-, or five-plus person households; 23 percent lived in two-person households.

- **The uninsured are geographically split** – About half of the uninsured lived in Rhode Island's core cities, and about half lived outside of the core cities.

Access to health care for the uninsured

According to results from the 2001 HIS[22], where an individual goes for care was greatly affected by insurance status.

- Over 50 percent of the uninsured went to private doctors.

- Eighteen percent of the uninsured went to community health centers.

- Fifteen percent of the uninsured went to a hospital emergency department or to a free-standing walk-in clinic. Another 11 percent of the uninsured reported that a hospital clinic was their usual source of care when ill.

Access to care was significantly affected by an individual's insurance coverage. While the majority of the uninsured did access care, they were less likely to see a doctor for routine care as opposed to having a visit when sick or injured. More than one-third of the uninsured did not see

[22] *Ibid.*

a doctor at all within the past 12 months, whereas only 10 percent of the insured population did not see a doctor. Yet, 80 percent of the insured had a routine doctor's visit during the last 12 months, as compared to only 50 percent of the uninsured.

Insured children, women, and Hispanics were also more likely to see a doctor and have a routine doctor's visit than uninsured children, women, and Hispanics.

Only about 2 percent of the insured population indicated that they did not get needed medical treatment because of cost, as compared to 28 percent of the uninsured.

Rhode Island's Approach to Covering the Uninsured

The State of Rhode Island has approached uninsurance in the population incrementally. In November of 1993, Rhode Island was granted a Section 1115 Waiver by the U.S. Department of Health and Human Services (HHS) to develop and implement its mandatory Medicaid managed care demonstration program called RIte Care. Implemented in August 1994, RIte Care was designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)[23] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

Since its inception RIte Care has been expanded eight times and now covers:

- Children under age 19 living in families with incomes less than 250 percent of FPL
- Pregnant women with incomes less than 250 percent of FPL
- Parents of children with family incomes less than 185 percent FPL
- Children with special health care needs, including those eligible for Medical Assistance due to:
    - Foster care (substitute placement) (up to age 21)
    - Subsidized adoptive placements (up to age 21)
    - Supplemental Security Income (SSI, up to age 21)
    - The Katie Beckett provision (up to age 18)

RIte Care's enrollment grew substantially from 1998 through 2001 as a result of four significant and concurrent events**:**

- The State expanded eligibility to parents and relative caretakers of RIte Care-enrolled

[23] Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF). FIP is Rhode Island's program for the TANF-eligible population.

children up to 185 percent of the FPL, under Section 1931 of the Social Security Act.

- The State streamlined the RIte Care application process, by creating a short, mail-in application in English and Spanish and eliminating face-to-face interviews for both the initial eligibility determination and for re-determination.
- The State embarked on an ambitious community-based outreach campaign to reach and enroll uninsured children and families.
- The State's commercial insurance market began to deteriorate, marked by sharp increases in premium rates offered to employers, reduced competition as a result of the exit of two of the State's commercial insurers (i.e., Harvard Pilgrim and Tufts), and significant hospital and health plan losses.

Over the same period of time, RIte Care's enrollment grew by 41 percent – from 74,000 in November 1998 to 104,000 by June 2000. Before that time, RIte Care enrollment had remained relatively stable despite the incremental expansions in coverage for children**.** The magnitude of the enrollment growth caused large, unexpected increases in program costs.

In January 2000, then Governor Almond convened a group of administration staff, legislative leaders, and consumer and business representatives to find a solution to Rhode Island's deteriorating health insurance market. The Health Care Steering Committee, as the workgroup was called, was jointly chaired by: the Director of the Rhode Island Department of Human Services (DHS); the Chair of the Senate Health, Education and Welfare Committee; and the House Majority Leader. The Steering Committee was broadly representative of employers, consumers, labor, and the legislative and executive branches of government. Health care providers and insurers were invited to attend meetings and provide testimony .

During the next six months, the Steering Committee focused on methods to stabilize the employer-sponsored health insurance market. Specifically, the Steering Committee examined methods to enable small businesses to maintain employer-sponsored health insurance by stabilizing premium rates and by assisting and encouraging low-wage workers to maintain employer-sponsored health insurance. The focus on small employers was due to the increasing number of businesses with less than 50 workers reporting the most volatile rate increases and the resulting difficulty in retaining and/or obtaining employer-sponsored health insurance, as well as the vital role these employers play in the State's overall economic health.

Governor Almond signed the resulting consensus legislative proposal into law on July 1, 2000. The legislation, Health Reform Rhode Island 2000, included the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

- **Part 1 – The RIte Care Stabilization Act** directing DHS to stabilize the RIte Care program by targeting resources to those most in need of coverage–low-wage families without access to affordable coverage, through:

    - Establishing cost-sharing requirements for certain RIte Care-eligible populations to promote both responsible utilization of health care services and development of additional disincentives for substitution

- Requiring mandatory participation in RIte Share of eligible individuals and families who have access to employer-sponsored health insurance. RIte Share[24] is the premium assistance program created by the statute to support employees in purchasing or retaining employer-sponsored health insurance.

- **Part 2 – Small Employer Health Insurance Availability and Affordability Act** directing the Department of Business Regulation to implement reforms in the health insurance marketplace to conform to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, stabilize premiums in the small group market by compressing rate bands, and guarantee issue of a basic health plan.
- **Part 3 -** New financial reserve requirements were established for health insurance, consistent with the recommendations of the National Association of Insurance Commissioners (NAIC).

RIte Care continues to be effective in covering low- income Rhode Islanders who would be otherwise uninsured. On June 30, 2004, 123,761individuals were enrolled in RIte Care.

Enrollment of both employees and employers into the RIte Share program has continued to grow since its inception. As of June 2004, almost 1000 employers participated in RIte Share and there were 5,127 RIte Share enrollees**.** Since February 2001, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers employed by 4,500 companies, who were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

Since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of their health insurance coverage if their income is above 150 percent of the FPL (e.g., $22,530 for a family of three). There were 5,205 families (13,142 individuals) active in cost-sharing at the end of December 2004.

Part 2 of Health Reform Rhode Island 2000, small group reform, has not gone as smoothly as RIte Share and premium collection portions of the statute. A study[25] of market conduct examinations of the effectiveness of Part 2 of the statute showed:

- The major Rhode Island carriers – BCBSRI, BlueChip, and UHCNE – provided virtually all the small employer health plans in the State.
- All three carriers delayed renewing a significant portion of their small employer groups to avoid compliance with the statute until October or November 2001.
- Important provisions of the statute were either not implemented or implemented incorrectly by the carriers, which affected all of the small employer groups.

[24] Under RIte Share individuals with access to employer-sponsored health insurance, irrespective of their being otherwise eligible for Medicaid, must enroll in the employer-sponsored plan. The State and the family share in the cost of the premium (the family's share is set so as not to exceed 5 percent of family income). RIte Share also covers the costs of co-payments and provides Medicaid-covered services not covered by employer-sponsored health insurance as wraparound benefits.

[25] Lautzenheiser & Associates. *Report on the Effectiveness of Rhode Island General Laws §§ 27-50-1 et seq. Small Employer Health Insurance Availability Act in Promoting Rate Stability, Product Availability, and Coverage Affordability*, June 30, 2002.

An example of the latter point was the rating portions of the statute. The statute had two phases of implementation in increasing a carrier's premium rating requirements, in order to mitigate the impact on employers and employees. The first phase began October 1, 2000. It included requirements to limit the spread of rates to a range of four-to-one from highest to lowest (i.e., 4-1 rate compression) and to limit rate adjustments for health status to ± 10 percent from the adjusted community rate. The second phase was scheduled to begin July 13, 2002, but was delayed by the Rhode Island General Assembly until October 1, 2004. The second phase was to limit the spread of rates to 2-1 compression and eliminate the use of health status in rating. Both aspects of the second phase were subsequently eliminated from the statute.

Recent Rhode Island Proposals to Cover the Uninsured

In 2004, Rhode Island's Secretary of State and Lt. Governor convened commissions that produced reports that recommended actions to be taken to provide greater access to health care in Rhode Island. To date these recommendations have not been authorized through legislation, other than the Lt. Governor's recommendation for a primary care pilot program which is the subject of this report.

The January 2004 Secretary of State Matthew Brown issued a report, entitled, *Health Insurance Options for Rhode Island Small Business,* which included three recommendations[26]:

- **RIte-Care Buy-in**. Low-income individuals and small employers with low-wage workers would be permitted to "buy-into" the RIte Care program. Small employers and individuals without access to employer coverage living below 300 percent of the FPL would be permitted to purchase coverage by paying a premium. To be eligible, employers would have 50 or fewer employees with median wages or salaries less that $30,000 per employee. An estimated 13,200 individuals would enroll in the program. The program would be entirely self-funded by premiums paid by employers and individuals. There would be no cost to the State.

- **Rhode Island Reinsurance Program.** The State would create a reinsurance program for health insurers covering small employers, sole proprietors and working individuals. It is estimated that premiums would be lower by 10% for participating employers and individuals. The projected cost of this program is $5.4 million, funded by income earned on health insurers' reserves in excess of 1.25 months of operating expense.

- **Cabinet Level Insurance Commissioner.** The position of Insurance Commissioner would be elevated to a cabinet level post. The cabinet level Insurance Commissioner would have greater authority, flexibility and responsibilities to address insurance-related issues, including that of affordable health insurance and provider rates of reimbursement.

In early 2004, Lt. Governor Charles Fogarty issued recommendations entitled, *Health Care Reform 2004: Moving Toward Excellence,* which made recommendations in three areas (i.e., controlling costs, expanding access and promoting quality and value). Within the many

[26]Lewin Group, prepared for Matthew Brown, RI Secretary of State, *Health Insurance Options for Rhode Island Small Business,* Jan 30, 2004

recommendations of this report, three focused on helping small business and the uninsured purchase health coverage[27]:

- **Create a RI Small Group/Individual Health Plan.** The State would provide small businesses (25 employees or less), the self-employed and individuals with an opportunity to subscribe to a State sponsored health plan by allowing them to buy-in to RIte Care, the State employees health plan or soliciting bids for private health plans to contract with the State to administer the new health plan.

- **Expand access for young adults.** Children over age 18 are not covered by RIte Care within a family/household unless they, themselves, qualify for RIte Care as a head of family, and children over age 18 are not covered by private insurance unless they are in school. It is proposed that RIte Care and private insurers cover children under family coverage until age 24 even if they are not in school.

- **Develop a Pilot Primary Care Program for the Uninsured.** The Departments of Human Services and of Health should collaborate on developing a pilot primary care program. Premiums would be income-based with subsidies and possibly catastrophic or reinsurance coverage from the state. Options should include a RIte Care buy-in, coverage through physicians and/or community health centers.

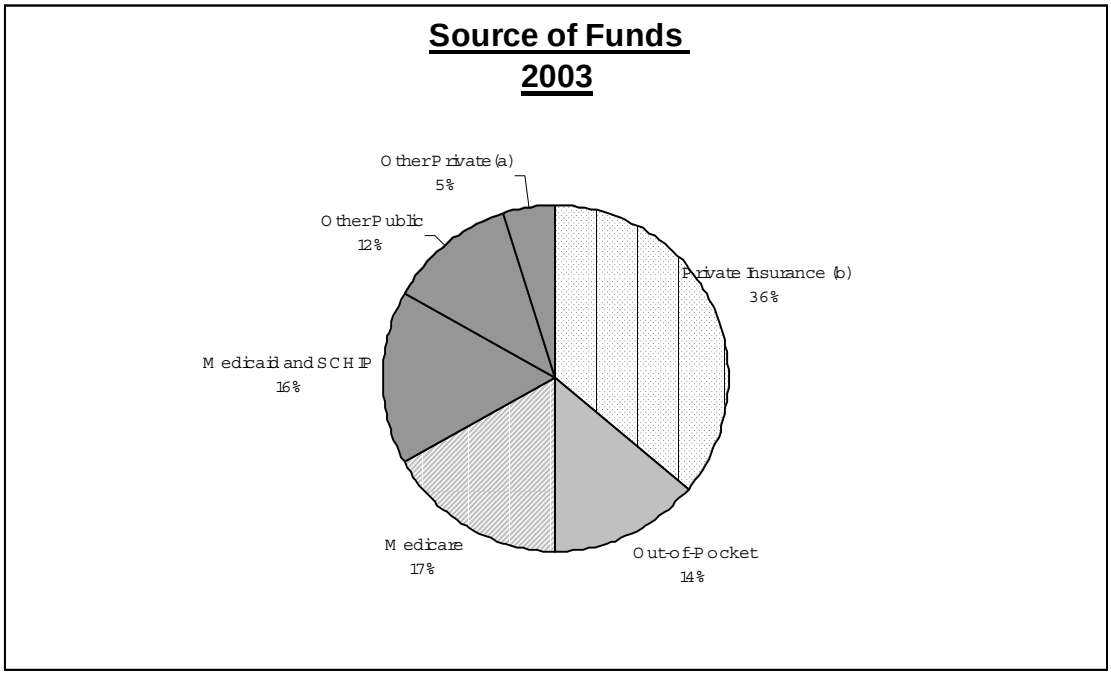
[27] Lt. Governor Charles Fogarty, *Health Care Reform 2004: Moving Toward Excellence*

HEALTH CARE COSTS

In 1980, the total spent on personal health care in Rhode Island was $973 million, and in 1990, it was $2.7 billion. By 1998, it had increased to $4.4 billion. On a per capita basis the figures for 1980, 1990 and 1998 were $1,027, $2,718 and $4,198 respectively. **Overall in 1998 (the most recent year available the state), Rhode Island's per capita health care expenditures were twenty percent higher than those for the United States overall**[28] .

At the national level, in 2003, personal health care expenditures per capita totaled $5,670 and represented 15.3% of the gross domestic product, rising three percentage points faster than the rest of the economy[29]. The figures below [30]represent the percentage distribution of personal health care spending by source and the application of funds in 2003. In terms of source of funds, Private insurance represents the largest percentage at 36%. Public funding from all sources combined (Medicare, Medicaid, SCHIP and other) is the source of 45% of all expenditures.

Figure 2
United States



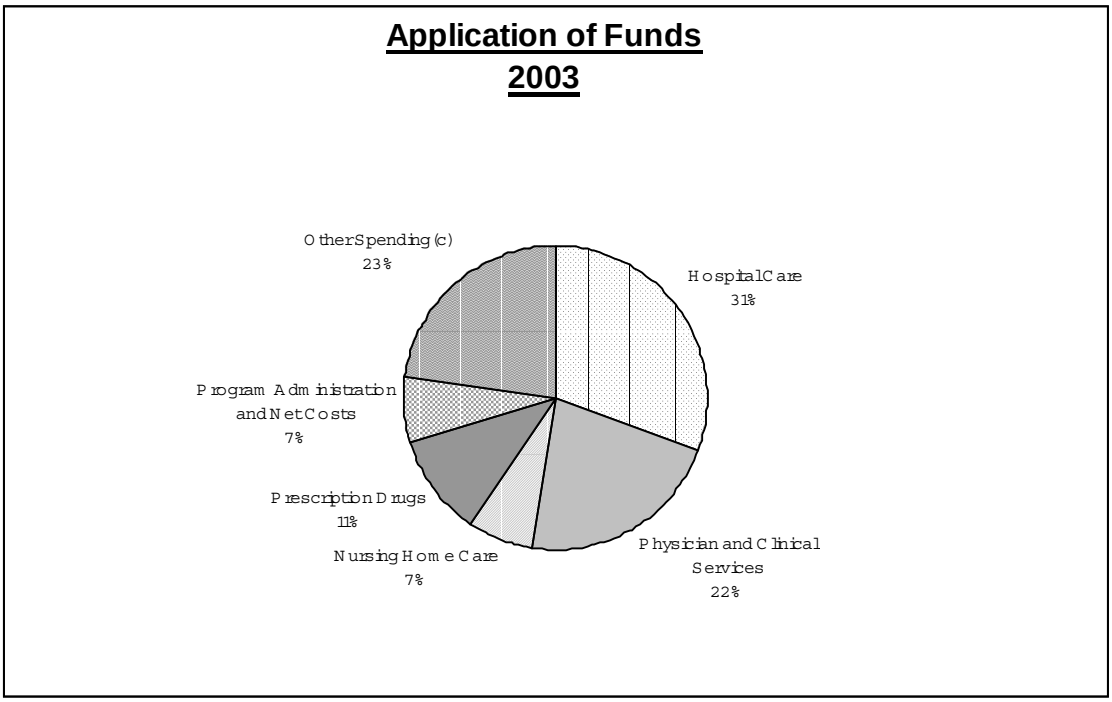
[a] "Other Public" includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health.

[2]b"Other Private" includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.

[28] United States, CMS, *United States Personal Health Care Expenditures (PHCE), All Payers 1980-98.* As cited in the *Annual Report 2002*, Governor's Advisory Council on Health.
[29] United States, CMS, *National Health Care Expenditures 2003-Highlights,*

[30] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Stat roup. Last updated January 2005

Figure 3
United States



c "Other Spending" includes dental services, other professional services, home health care, durable medical products, over-the-counter medicines and sundries, public health activities, research and construction.

In terms of the application of funds in 2003, the largest percentage of spending, 31% went to hospital care and the second largest, 22%, went to physicians and clinical services. Seven percent of spending went to administration.

According the Blue Cross and Blue Shield Association's 2004 *Medical Cost Reference Guide*[31], The key drivers of healthcare costs nationally, include the following:

> "-**Outpatient costs** are once again the fastest growing component of healthcare costs. Together, inpatient and outpatient hospital expenditures account for over half of the growth in private insurance healthcare spending growth between 2002 and 2003.
>
> -Rising **inpatient hospital costs** are being driven primarily by increasing hospital expenses per inpatient stay, which rose 5.4% from 2001 to 2002, to over $7,000. Rising costs per admission, in turn, are a result in part of greater use of expensive technology, higher labor costs, and hospital consolidation.
>
> -**Pharmaceutical costs** are projected to account for 12.2% of all healthcare expenditures in 2005, up from 9.3% in 2000. In 2002, the growth was due almost equally to inflation

[31] BCBS Association, Medical Cost Reference Guide, Revised October 2004.

and increased use, as well as changes in therapeutic mix and the introduction of new drugs, and offset in part by greater use of generic drugs.

-Increasing attention is being focused on the growing use and costs associated with **diagnostic imaging**. The number of imaging procedures in the US, for example, is projected to grow from about 300 million scans in 2001 to almost one-half of a billion in 2008.

-**Physician services** are the slowest growing component of healthcare costs, although they still make up about one-third of all healthcare spending. In addition, physicians have increased their involvement in ventures such as ambulatory surgery centers and specialty hospitals."[32]

The Cost of Employer-Based Coverage

Nationally, in 2003 the average annual premium cost for covered workers was $3,383 for single coverage and $9,068 for family coverage.[33] "Between 2002 and the spring of 2003, monthly premiums for employer-sponsored health insurance rose 13.9%, the third consecutive year of double-digit premium increases and the highest premium increase since 1990. Premiums increased substantially faster than overall inflation (2.2%) and wage gains for non-supervisory employees (3.1%)[34]. Based on the 2003 Kaiser and HRET national employer survey, many employers will increase employee contributions and cost sharing next year and a small but significant group say they are likely to offer a high-deductible plan in the next year.[35]

[32] *ibid*
[33] Kaiser Family Foundation and HRET, *Employer Health Beneifits-2003 Summary of Findings.* www.kff.org.
[34] *ibid*
[35] *ibid*

OTHER STATES' EXPERIENCES

Comprehensive Evaluation of State Efforts

In March 2004, *State Options for Expanding Health Care Access*, by Barbara Yondorf, Laura Tobler and Leah Oliver, described and assessed twenty-six state programs for expanding health care access. Based on their assessment, the report cites common components in successful coverage expansion programs[36]:

- Providing substantial *premium subsidies*
- Building on *existing programs and systems*
- Minimizing *administrative requirements* for program partners, such as insurers and employers.
- Having strong *marketing and outreach* efforts
- Streamlining *eligibility determination and enrollment*, and
- Allowing all *family members* to enroll in the same program.

Current Efforts in the Northeast

In the Northeast, successful models of care that incorporate one or more of these design features are described below.

Maine "Dirigo Choice": Implemented in 2004, in this program the State facilitates the purchase of employer-sponsored health coverage and expands on the Medicaid program to include more children and families. Currently, 216 small businesses and 867 sole proprietors are currently enrolled or are enrolling for February 1, 2005. More than 2,700 residents have also applied. Dirigo attempts to lower costs through strengthened oversight, public price lists, caps on insurers' costs and operating margins, and financial incentives to enrollees.[37]

Healthy New York: Implemented in 2001, this is a state subsidized reinsurance program targeting adult, working uninsured with a streamlined benefits package. Facilitated by the state, the program is marketed through licensed health plans to small employers, sole proprietors and individuals who have not been insured in 12 months.[38] (See more about Healthy New York under the section on Reinsurance).

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[36] *State Options for Expanding Health Care Access*, by Barbara Yondorf, Laura Tobler and Leah Oliver (March 2004). NCSL's Health Priorities Project, including this series of papers, was supported in part by cooperative agreements from two funding organizations: the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (project 6 U93 MC 00110-12); and the Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (project U38/CCU814942). In addition, this paper was also sponsored in part by the Bureau of Primary Health Care,, U.S. Department of Health and Human Services (project 6 U30CS00165-09-01).

[37] "Dirigo has Successful First Year," September 13, 2004, Governor's Office of Health Care Policy and Finance.
"DirigoChoice Coverage Celebrated by Maine Businesses," January 3, 2005, Governor's Office of Health Care Policy and Finance.
"State Options for Expanding Health Care Access," Barbara Yondorf, Laura Tobler, and Leah Oliver, Balancing Needs with Resources: Analysis of Provocative Ideas in Health Care, National Conference of State Legislators, March 2004.
"Dirigo Health Fast Facts." Augusta, ME: Office of Health Policy and Finance.
"Maine Legislature Approves Universal Health Plan." Kaiser Health Daily Report, June 16, 2003.

[38] "Profiles in Coverage: Healthy NY," State Coverage Initiatives, January 2005.
"Report on the Healthy NY Program 2004, Prepared for the NY State Insurance Department," EP&P Consulting, Inc., December 31, 2004.

In addition, Massachusetts and Vermont are currently considering comprehensive health care reform measures and New Hampshire is considering repealing 2003 legislation that changed its health insurance rating system:

Massachusetts: Governor Romney's proposal calls for a minimum benefit package to be offered by commercial insurers to individuals and small businesses, while enhanced marketing and outreach of the Medicaid program is proposed to help cover additional 100,000 uninsured. "Pay or play" provisions include incentives for businesses to offer health insurance, penalties through increased minimum wage, inability to bid on state contracts, and public notification (window stickers) stating they do not provide employee health insurance benefits. Safety Net Care, targeting long-term unemployed and working poor, would replace the uncompensated care pool, to manage treatment through network of clinics, community health centers, and hospitals[39].

Vermont: Governor Douglas' proposal calls for a combination of tax credits, reinsurance, Health Savings Accounts, wellness benefits, and a prescription drug measure, all aimed at lowering costs, reducing premiums, and stabilizing the individual insurance market. A high risk pool—Small Market Access Reinsurance Trust--aims to lower premiums and stabilize the market, while encouraging the return of insurance carriers to the state. A tax credit for small business is planned to encourage small employers to insure workers. A Premium Discount Program will offer 10,000+ Vermonters a discount on purchasing a group plan in the private market. A multi-state buying pool for pharmaceuticals has been formed with six states and has resulted in $2 million savings last year and $3 million projected in 2005.[40]

New Hampshire's 2003 effort at health care reform was regulatory in nature. SB 110, passed in 2003, redefined small group employer to employers with 1-50 employees (from 1-100) and changed the state's insurance rating system from community-based to demographic-based. Since then, premiums are reported to have increased up to 100% for some sole proprietors and small businesses. According to *Kaiser StateHealthFacts.org* (MEPS IC), New Hampshire has the highest average annual cost of employment-based insurance for family coverage of any state in the nation.[41]

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[39] "Health Care Expansion for Poor in the Works," David Kibbe, Ottaway News Service, 12-24-04.
"Issue: Health Insurance Reform," IssueSource.org, Massachusetts Politics and Policy Online.
"My Plan for Massachusetts Health Care Reform," by Governor Mitt Romney, The Boston Globe, November 21, 2004, as reported on the NGA website, 12-21-04.
"Romney Plan Would Expand Healthcare," Scott S. Greenberger, Boston Globe, November 21, 2004.

[40] "A Common Purpose," Second Inaugural Address, January 6, 2005, Governor James H. Douglas.
"Democrats, Governor at Odds Over Universal Health Coverage," Rutland Herald, January 2, 2005.
"Douglas Vows to Work on Health Insurance," The Caledonian-Record Online Edition, December 29, 2004.
"Governor Douglas Details Health Reform Plan," Press Release, September 14, 2004.

[41] "Republicans Block Discussion of Problems with New Health Insurance Law," Press Release, Office of Senate Minority Leader Sylvia Larsen, March 5, 2004, PoliticsNH.com, New Hampshire's Online Political Network.
"An Act relative to small group health insurance coverage and relative to health plan loss information." Senate Bill 110 Final Version, Chapter 188, April 3, 2003.

Assessments of Limited Benefit Plans and Reinsurance

The State Coverage Initiative program of the Robert Wood Johnson Foundation has prepared Issue Briefs that assess two strategies that have been tried by the many states to improve access, i.e., limited benefit plans and reinsurance. Below is a summary of the finding on each topic.

Limited Benefit Plans

Limited-benefit policies[42] do **not** include some, or maybe all of the benefits that have been mandated by State law over the past three decades in an effort to make available a lower-cost health insurance product in a State marketplace.

To date, at least 11 States have considered or enacted legislation to permit insurers to sell limited-benefit policies to small groups. The general observation made concerning these programs is that they have not sold well in the marketplace. For example, in Minnesota, which has the oldest law on the books, no insurers ever offered the product. In New Jersey, only about 500 have bought the product as of July 2004. Similarly, in Florida less than 200 had bought the product as of June 2004.

More detail on any of the above plans may be found in Friedenzohn[43], where she also summarized this experience as follows:

> "The low demand for limited benefits to date in states that have authorized these plans exposes an important disconnect: Many employees believe that benefit exclusions are an acceptable way to achieve affordable health insurance coverage, but most would not want such coverage for themselves. In addition, when asked to specify the services they would want covered in a basic plan, employers produced lists that looked very similar, if not identical, to the comprehensive plans that they say they cannot afford."

Reinsurance

Reinsurance is often considered as a mechanism to mitigate risk and, thereby, to hold down premium costs Reinsurance may be defined[44] as follows: "The transfer of part of an insurance risk to another insurer or group of insurers." It is commonly used for commercial health insurance products, particularly managed care products, either on an aggregate basis or for a specific benefit (e.g., inpatient hospital). RIte Care-participating Health Plans, for example, are required to have it. Reinsurance was offered as a solution to Rhode Island's uninsurance problem by the group[45] convened by the Secretary of State, Matthew Brown.

State efforts to sponsor reinsurance programs to help contain premium increases particularly for small businesses date back to the 1980's. Deborah Chollet[46], in an excellent review of these efforts, notes[47]: **"Currently, at least 21 states have reinsurance pools, though many have**

[42] Friedenzohn, I. "Limited-Benefit Policies: Public and Private-Sector Experiences", *State Coverage Initiatives Issue Brief*, V (1), July 2004.
[43] *Ibid*.
[44] Darold, T.A. *Health Insurance Answer Book: 1994 Cumulative Supplement*, Panel Publisher, New York, NY, 1994, GL-27.
[45] The Lewin Group. *Health Insurance Options for Rhode Island Small Businesses*, January 30, 2004.
[46] Chollet, D. "The Role of Reinsurance in State Efforts to Expand Coverage", *State Coverage Initiatives Issue Brief*, V (4), October 2004.
[47] *Ibid*, 2.

very low enrollment and some are inactive." She highlighted the following "conventional" reinsurance programs:

- **Connecticut** (1990) – The Small Employer Reinsurance Pool reinsures all small-group carriers in the State, which, in turn, are required to guarantee issue coverage to groups of 1 to 50 employees (and their dependents). Insurers pay a $5,000 deductible per reinsured life. As of October 2004, 3,116 individuals were enrolled in the pool, with an annual reinsurance premium of $4,500 per year. The program is funded by reinsurance premiums paid by insurers.

- **Idaho** (1994) – Under the Small Employer Health Reinsurance Program, the small-group carrier is responsible for the first $12,000 in claims and 10 percent of the next $13,000 (basic), $88,000 (standard), or $120,000 (catastrophic) in claims. As of April 2004, 44 small-group plans were reinsured through the program. Like Connecticut, the program is funded by reinsurance premiums. In addition, the State has an Individual High-Risk Reinsurance Pool, under which the carrier pays the first $5,000 in benefits, as well 10 percent of the next $25,000. The pool fully reinsures over $25,000. As of March 2004, 1,358 individuals were in the pool, which is funded by reinsurance premiums and part of the State's premium tax.

- **Massachusetts** (1992) – The Small Employer Health Reinsurance Plan is for firms with less than 50 employees, sole proprietors or partners, and dependents, but at least 75 percent of the employees must enroll at both issue and renewal. The carrier pays the first $5,000 in covered claims, 10 percent of the next $50,000, and fully anything above that. Premiums range from $800 to $1,000 per employee per month. As of October 2004, eight plans were reinsuring 13 individuals. In addition, there is a Nongroup Health Reinsurance Plan under which the primary insurer covers the first $10,000, 10 percent of the next $40,000, and all of claims over $50,000. The premiums range from $4,000 to $6,500 per adult member per month and $4,500 to $7,800 per child member per month, depending on the type of primary plan (e.g., indemnity) and whether or not there is drug coverage. As of October 2004, three individuals were enrolled.

- **New Mexico** (1994) – The New Mexico Health Insurance Alliance (NMHIA) provides coverage for groups with less than 50 employees, self-employed workers, and individuals who lost coverage involuntarily. NMHIA withholds a reinsurance premium from premiums paid to carriers – five percent the first year and up to 10 in renewal years for small groups and 10 percent the first year and up to 15 percent for renewals for individuals. As of October 2004, 11 carriers covered nearly 4,000 individuals, 65 percent of whom were in small groups.

Chollet also highlighted two "subsidized" reinsurance programs:

- **Arizona** – The Health Care Group (HCG) offers coverage to small firms and the self-employed. For groups of six or more, 80 percent of employees must participate; 100 percent must participate for groups less than six. The State appropriates $4 million a year (through 2006) to protect plans from medical losses that exceed 86 percent of premiums

and to buy reinsurance for claims in excess of $100,000. As of August 2004, HCG covered 11,734 individuals, 70 percent of whom were sole proprietors.

- **New York** – Perhaps the most widely known reinsurance plan, Healthy New York (NY) covers low- to middle-wage workers (in firms with 50 or fewer individuals, if at least 30 percent of employees earn less than $32,000 annually, if the employer did not offer or contribute substantially (more than $50 per month) to comprehensive group coverage in the prior year), sole proprietors, and individuals. At least half of eligible employees must participate. Sole proprietors and individuals with gross household income up to 250 percent of the FPL may participate, if they have been uninsured for the last year and are not eligible for Medicare. Healthy NY only contracts with health maintenance organizations (HMOs) and the HMOs may receive reimbursement from the State for 90 percent of claims between $5,000 and $75,000 for any member in a calendar year. As of October 2004, 24 HMOs were participating and there were approximately 67,000 "active" enrollees with approximately 5,000 new enrollees per month. Premiums are community-rated. The program expects to reach 110,000 net enrollees by the end of 2005.

Other than subsidies having a specific effect on enrollment levels, Chollet notes[48] the following "lessons" for States:

- Reinsurance programs can be useful for States with very different market rules, and for both individual and small-group markets

- Reinsurance premiums, benefits, and insurer participation rules are important to the success of the pool

- Even with reinsurance, State health insurance purchasing programs are vulnerable to adverse selection when they attempt to do what the market does not

- States can ease protection against adverse selection in a reinsured health insurance purchasing program – and widen access to the subsidies that the program offers – by balancing program rules and market rules

"Catastrophic" insurance is another way to mitigate the insurer's risk and, thereby, hold down premiums. Catastrophic insurance is typically defined as a *high-deductible plan*, where deductible may be defined[49] as: "An amount that a covered individual must pay before an insurance program begins reimbursing for eligible expenses." Perhaps the best known of the *high-deductible plans* presently is Health Savings Accounts (HSAs), which has been a centerpiece of the Bush Administration's efforts to contain ever-escalating premium increase. HSAs are available to any individual covered under a high-deductible health plan (HDHP), who

[48] *Ibid*, 4.
[49] Darold, T.A. *Op.Cit..*, GL-10.

is not also covered by other health insurance or by Medicare. A qualifying HDHP, which may be individual or job-based coverage, must have:

- An annual deductible of at least $1,000 for individual coverage and at least $2,000 for family coverage, except there is no deductible for preventive care
- Annual out-of-pocket costs not exceed $5,000 for individuals and $10,000 for families

Contributions can be made by employers, employees, the self-employed, and individuals with non-job-based health insurance. Contributions to HSAs are deductible, up to $2,600 for individuals, and $5,150 per year for families. HSAs pay for qualified medical expenses, and may also pay for COBRA premiums; health insurance premiums while unemployed, qualified long-term care insurance premiums, and Medicare-related expenses except for Medigap premiums. Kofman[50], in an excellent review of the pros and cons of HSAs, notes:

> "Whether HSAs can expand coverage or lower health care costs is a matter of debate. HSA supporters and detractors generally agree that HSAs will shift the cost burden for health care decisions onto consumers."

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[50] Kofman, J. "Health Savings Accounts: Issues and Implementation Decisions for States", *State coverage Initiatives Issue Brief*, V (3), September 2004, 4.

RHODE ISLAND PROPOSAL

Given the foregoing as a backdrop, the following is a proposal to develop a health plan that is responsive to the needs of all stakeholders: employers, employees, insurers and agents and providers.

Objectives: Address the affordability of health care and reduce the uninsured

- The populations "at risk of uninsurance" need more choices for coverage. At risk populations include:
    - Working individuals and their dependents whose employer does not offer health care coverage , who are not eligible for their employer's coverage or cannot afford or are struggling to afford coverage;
    - Self-employed individuals and dependents who cannot afford or are struggling to afford coverage;
    - Unemployed individuals and their dependents who are uninsured and cannot afford or are struggling to afford COBRA or "direct pay" coverage.
- Health insurance rates, particularly for small employers, should have reasonable and stable annual trends, as well as minimal year-to-year volatility, resulting in an increased number of employers who offer health insurance to their employees.
- When offered, enrollment in employer-sponsored health insurance should be affordable to all workers, resulting in:
    - An increased number of working Rhode Islanders enrolling in Employer sponsored coverage
    - An increased number of working families switching from RIte Care to RIte Share

Approach

- The State should design and assess the feasibility of a plan, with public input, which should be offered to Rhode Island small businesses.
- The health plan should incorporate the flexibility to include features which ensure affordability for employers and employees.
- The State should issue a Request for Proposals for health insurers to offer this plan.
- The State should create a reinsurance program for hospital costs, built around the principle of supplementing the cost of hospital services for all enrollees in the plan.
- The State should build on the lessons-learned from the RIte Care program, in particular, the oversight and monitoring function, which should ensure the appropriate implementation, operation, reporting, and evaluation of the plan in accordance with terms set by the State.

Design Principles

The design principles for the plan are as follows:

- Utilize value-based purchasing and "pay for performance" methods to ensure quality, utilizing access and quality standards as well as incentives for quality improvement.
- Provide incentives to providers and enrollees to emphasize access to primary and preventive care, as well as management of chronic diseases.
- Make the quality and cost of services transparent.
- Create a benefit design that encourages rational consumer behavior based on quality and cost considerations.
- Incorporate consumer education as well as consumer incentives to promote healthy behaviors.
- Incorporate employer support and incentives to promote workplace wellness activities.
- Provide affordable access to quality, medically necessary care.
- Provide access to a coordinated, accessible organized delivery system that incentivizes enrollees to seek and receive care in the most appropriate and lowest cost setting, incorporating a quality, accessible system of community-based health services and as little as possible reliance on institutional-based services.
- Build on evidence-based practice standards for covered services and service delivery models.
- Make the plan simple to navigate for enrollees and providers.
- Be flexible in design to be able to incorporate new design concepts, such as Health Savings Accounts.

Financing Principles

The financing principles for the plan should be as follows:

- Medically necessary services in the lowest-cost setting should be fully insured.
    - Services components covered by the premium (i.e., financed by the monthly combined employer/employee premium) should include:
        - The full cost of primary/preventive care, disease management, care management, non-emergency sick care in community-based settings, and patient education
        - The full cost of medically necessary specialty and ancillary service (e.g., specialists, imaging, and laboratory) delivered by providers that are both quality-qualified and that are the least costly to the insurer.
        - The full cost of medically necessary hospital care at qualified facilities/institutions offering a payment mechanism that emphasizes cost-efficient care.
- Qualified providers who participate in the plan at a higher contractual rate should also be accessible; however, the additional cost beyond the least cost "allowance" should be borne by the enrollees and should not be part of the "insured" premium (whose costs are passed on to the employer and all employees).
- Employer-paid and employee-paid monthly premiums should assure access to affordable medically necessary care for all members. Members choosing to use higher cost care settings pay the additional cost above the allowable amount.

Next Steps

This proposal will be referred to the Health Care Cabinet, newly constituted by the Governor, which will be chaired by the Commissioner of Health Insurance. The Cabinet will continue to develop and, if recommended, implement the proposal. Activities to be considered by the Cabinet shall include:

- Meeting with stakeholders to elicit their input on the proposed objectives, approach, design principles, and financing principles
- Refining or adjusting the proposed objectives, approach, design principles, and financing principles as needed
- Identifying opportunities or limitations in State law to the plan, and ways to capitalize on the opportunities or overcome the barriers
- Fleshing out the details of the plan
- Conducting a financial feasibility study of the proposed plan